To: 1102 Grand Ave MMR; Kansas City, MO 64106

This is an Evergreen service / RHC # 793352

HCP:

17908

FRN

1691146

Bluebird Network

acct # NWMEDC

Spin:

143027882

20M PTP VLAN Ethernet

ID ALBB-VLAN-14314-01-KCBM

This circuit was removed 8/1/16

Rural Rate:

\$3250.00

Urban Rate:

\$199.96

Health Care Providers Universal Service Funding Request and Certification Form

Approval by OMB 3060—0804

The deadline to submit this form is the June 30th end of the funding year.

Estimated time per response: 3 hours

Blo	ck 1: HCP Information		
1	HCP Name Northwest Medical Center		2 HCP Number 17908
3	Form 465 Application # 43143596 4 Consc	ortium Name (If any)	
Blo	ck 2: Bill Payer Information		
5	Billed Entity Name Northwest Medical Center		6 Billed Entity FCC RN 0002504975
7	Contact Name James Crouch		
8	Address Line 1 705 N College Street		
9	Address Line 2		
10	City Albany		11 State MO 12 Zip 64402
	Contact Phone # 660-726-1261 14 Fax #		15 Email james.crouch@northwestmedicalce
	ock 3: Funding Year Information		
16	Funding Year - Check only one box Year 2014 (7/1/2014-6/30/2015)	Year 2015 (7/1/2015-6/30)/2016) × Year 2016 (7/1/2016-6/30/2017)
Blo	ock 4: Service Information	Teal 2010 (11112010-0100	(17 1720 10 - 0100120 17)
17		quired) PTP 20M Ethe	rnet
18	Total Billed Miles O		wable Distance (From Form 465)
20	Percentage of HCP's service used for the provision of he	ealth care. 100	(If less than 100%, please explain.)
	If the HCP indicated it is a part-time eligible entity (on Fo		
	Connection information	Carrier At July 1914	Carrier B (arter C Carrier D)
21	Service Provider Name	Bluebird Network	
22	Service Provider Identification Number (SPIN)	143027882	
23	Service Provider Contact Person Name	Michael Morey	
24	Service Provider Contact Person's Phone #	816-361-8821	
25	Service Provider Contact Person Email	michael.morey@bluebird	
26	Circuit Start Location	705 N College, Albany MO	
27	Circuit Termination Location	1607 E Hwy 136, Albany MO 64402	
28	Billing Account Number	NWMEDC	
29	Tariff, Contract or other document reference number	793354	
30	Date Contract Signed or Date HCP Selected Carrier	11/14/2014	
31	Contract Expiration Date (mm/dd/yyyy or NA if MTM)	12/28/2017	
32	Service Installation Date	12/29/2014	
33		1800.00	
34	If you are a consortium member OR have multiple carrinterconnect and which carrier(s) provides each circuit s		it Diagram to show how the sites agram included: Yes x No
35	Are you a mobile rural health care provider?	Yes x No If yes, se	e instructions and attach a list of all sites to be served.

	THE RESIDENCE OF THE PROPERTY
IF YOU ARE REQUESTING SUPPORT FOR MILEAGE-BASED CHARGES, COMPLE	ETE BLOCK 5 ONLY AND SKIP BLOCK 6. (PLEASE SEE
INSTRUCTIONS). IF YOU ARE REQUESTING SUPPORT BASED ON URBAN/RURA	
COMPLETE ONLY BLOCK 6. YOUR APPLICATION CANNOT BE PROCESSED IF B	SOTH BLOCKS ARE COMPLETED.
Block 5: Mileage-based Charge Discount Request	
Complete this block if you are seeking support for mileage (distance-based) charges or	nly. Do not enter any other charges in this block. You may need
to ask your service provider representative to provide this information	
36 Billed Circuit Miles	
37 Monthly Mileage Charges (Exclude Channel Termination chgs, etc.)	
38 Cost per Mile per Month	
If Line 33 equals Line 37, please ensure that ONLY mileage-related charges	are included in Line 37. (See Instructions.)
Block 6: Comprehensive Rate Comparison Request	elements of your telecommunications service necessary for
Complete Block 6 if you have not completed Block 5 and are requesting support for all the provision of health care. The information in this block will establish the difference be	etween the urban and rural rates for your requested service.
Please contact RHCD at (800 453-1546 if you need assistance.	etween the diban and raid rates is your requests
39 One-time Urban Rate Charge (in selected large city)	
40 One-time Rural Rate Charge (in city where HCP is located)	
41 Monthly Urban Rate (in selected large city). From RHCD	
website: or Other rate documentation attached:	
If your circuit includes charges for mileage over the Maximum Allowable Dist., (Lin	ne 19), please complete Lines 42 to 44. Otherwise, skip to Block 7.
42 Billed Circuit Miles	
43 Monthly Mileage Based Charges	
44 Cost per Mile per Month	
Block 7: Bid Documentation	ed on the RHCD website?
45 Did you receive any bids in response to the Form 465 Request for Services posts	ed on the KHOD website? [
If you checked yes, copies of the bids MUST be submitted to RHCD. Block 8: Certification	
46 x I certify that the above named entity has considered all bids received and	selected the most cost-effective method of providing the
requested service or services. The "most cost-effective service" is defined	I in the Universal Service Order as the service available at the
lowest cost after consideration of the features, quality of transmission, reli	iability, and other factors that the health care provider deems
necessary for the service to adequately transmit the health care services	required by the health care provider.
47 x Pursuant to 47 C.F.R. Secs. 54.601 and 54.603, I certify that the HCP or	
requirements herein and will abide by all of the relevant requirements, inc	luding all applicable FCC rules, with respect to universal
service benefits provided under 47 U.S.C. Sec. 254. I understand that any	v letter from RHCD that erroneously states that funds will be
made available for the benefit of the applicant may be subject to rescission	on.
48 x I hereby certify that the billed entity will maintain complete billing records	
49 x I certify that I am authorized to submit this request on behalf of the above form and attachments and that to the best of my knowledge, information,	and belief, all statements of fact contained herein are true.
50 Signature My u h	51 Date 7/18/2017
52 Printed name of authorized person Geoff Boggs	53 Title or position of authorized person CEO
54 Employer of authorized person USF Healthcare Consulting, Inc	55 Employer's FCC RN 0018694075

- You must submit one Form 466 for each service (i.e., circuit) for which you request reduced rates. For example:
 - If you are requesting reduced rates for two T1 lines, you must submit two Forms 466.
 - If you are requesting reduced rates for two ISDN lines & one Frame Relay line, you must submit three Forms 466.
- If the service described on this form is subject to the 28-day competitive bidding requirement, do not select a carrier or complete the Form 466 before or during the 28-day posting period.
- You must provide evidence of the urban rate if you have completed Block 6 and have not used the urban rates from the website.
- This form, attachments, and supporting documents should be combined in one envelope and sent to the RHCD.
- If the service described on this form changes (e.g., rate change) during the funding year, you must notify RHCD immediately and submit a revised Form 466.
- If you have any questions, contact RHCD at (800) 453-1546.

Persons willfully making false statements on this form can be punished by fine or forfeiture under the Communications Act, 47 U.S.C. Secs. 502, 503(b), or fine or imprisonment under Title 18 of the United States Code, 18 U.S.C. Sec. 1001.

FCC NOTICE FOR INDIVIDUALS REQUIRED BY THE PRIVACY ACT AND THE PAPERWORK REDUCTION ACT

Part 3 of the Commission's Rules authorize the FCC to request the information on this form. The data reported will be used to ensure that health care providers have selected the most cost-effective method of providing the requested services as set forth in 47 C.F.R. Section 54.603(b)(4). The information will be used by the Universal Service Administrative Company and/or the staff of the Federal Communications Commission, to evaluate this form, to provide information for enforcement and rulemaking proceedings and to maintain a current inventory of applicants, health care providers, billed entities, and service providers. No authorization can be granted unless all information requested is provided. Failure to provide all requested information will delay the processing of the application or result in the application being returned without action. Information requested by this form will be available for public inspection. Your response is required to obtain the requested authorization.

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THE FOREGOING NOTICE IS REQUIRED BY THE PRIVACY ACT OF 1974, PUBLIC LAW 93-579, DECEMBER 31, 1974, 5 U.S.C. 552a(e)(3) AND THE PAPEWORK REDUCTION ACT OF 1995, PUBLIC LAW 104-13, OCTOBER 1, 1995, 44 U.S.C. SECTION 3507.

To: 1607 E Hwy 136; Albany, MO 64402

This is an Evergreen service / RHC # 793354

HCP:

17908

Bluebird Network acct # NWMEDC

Spin

143027882

20M PTP VLAN Ethernet ID ALBB-VLAN-14309-02-ALBB

Rural Rate:

\$1800.00

Urban Rate:

2 x 99.98 = 199.96

Health Care Providers Universal Service Funding Request and Certification Form

Approval by OMB 3060—0804

The deadline to submit this form is the June 30th end of the funding year.

Estimated time per response: 3 hours

Blo	ck 1: HCP Information							
1	HCP Name Northwest Medical Cente	r			2 HCP N	lumber 1	17908	
	Form 465 Application # 43143596	4 Conso	ortium Name (If any	/)				
Blo	ck 2: Bill Payer Information							
5	Billed Entity Name Northwest Medical C	enter			6 Billed I	Entity FC	C RN 00025	504975
	Contact Name James Crouch							
_	Address Line 1 705 N College Street							
	Address Line 2				T			
	City Albany				11 State		12 Zip 644	
	Contact Phone # 660-726-1261	14 Fax#			15 Email	james.	crouch@no	rthwestmedicalce
	ock 3: Funding Year Information							
16	Funding Year - Check only one box Year 2014 (7/1/2014-6/30/2015)		Year 2015 (7/1/20	15-6/30	0/2016)	×]Year 2016 (7/	/1/2016-6/30/2017)
	ock 4: Service Information							
17	Type of Service & Circuit Bandwidth (Docum	nentation red						
18	Total Billed Miles 0		19 Maximu	m Allo	wable Distan	ce (From	n Form 465)	101
20	Percentage of HCP's service used for the pr			100	`		10%, please ex	plain.)
	If the HCP indicated it is a part-time eligible	entity (on Fo	orm 465), describe	metho	d of allocatin	g prorate	ed support.	
								-
Brown and Arranges	િonneallon Information		Carrier A		Carrier B		Carrier C	Carrier D
21	Service Provider Name		Bluebird Network					
22	Service Provider Identification Number (SPI	N)	143027882					
23	Service Provider Contact Person Name		Michael Morey					
24	Service Provider Contact Person's Phone #		816-361-8821					
25	Service Provider Contact Person Email		michael.morey@blueblr	te _				
26	Circuit Start Location		705 N College, Albany N 64402	1				
27	Circuit Termination Location		16 W 4th St. Grant City, MO 64456	£1				
28	Billing Account Number		NWMEDC	<u> </u>				
29	Tariff, Contract or other document reference	e number	836350					
30	Date Contract Signed or Date HCP Selecte	d Carrier	11/14/2014					
31	Contract Expiration Date (mm/dd/yyyy or N	A if MTM)	11/13/2017					
32	Service Installation Date		5/18/2015					
33	Actual Rural Rate per Month (Enclose Docu	umentation)	3000.00					
34	If you are a consortium member OR have n interconnect and which carrier(s) provides of				uit Diagram to Piagram inclu		ow the sites Yes	x No
35	Are you a mobile rural health care provider	?	Yes x No If	yes, se	ee instruction	s and at	tach a list of all	I sites to be served.

IF YOU ARE REQUESTING SUPPORT FOR MILEAGE-BASED CHARGES, COMPL	ETE BLOCK 5 ONLY AND SKIP BLOCK 6. (PLEASE SEE
INSTRUCTIONS). IF YOU ARE REQUESTING SUPPORT BASED ON URBAN/RUR	AL RATE COMPARISON, SKIP BLOCK 5 AND
COMPLETE ONLY BLOCK 6. YOUR APPLICATION CANNOT BE PROCESSED IF I	
Block 5: Mileage-based Charge Discount Request	
Complete this block if you are seeking support for mileage (distance-based) charges of	nly. Do not enter any other charges in this block. You may need
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39 One-time Urban Rate Charge (in selected large city)	
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website: or Other rate documentation attached:	40) I was a late Linear 40 to 44. Otherwise alkin to Block 7
If your circuit includes charges for mileage over the Maximum Allowable Dist., (Li	ne 19), please complete Lines 42 to 44. Otherwise, skip to block 7.
42 Billed Circuit Miles	
43 Monthly Mileage Based Charges	
44 Cost per Mile per Month	
Block 7: Bid Documentation	
45 Did you receive any bids in response to the Form 465 Request for Services post	ed on the RHCD website? Yes x No
If you checked yes, copies of the bids MUST be submitted to RHCD.	
Block 8: Certification	
46 x I certify that the above named entity has considered all bids received and	selected the most cost-effective method of providing the
requested service or services. The "most cost-effective service" is defined	I in the Universal Service Order as the service available at the
lowest cost after consideration of the features, quality of transmission, rel	ability, and other factors that the health care provider deems
necessary for the service to adequately transmit the health care services	
47 x Pursuant to 47 C.F.R. Secs. 54.601 and 54.603, I certify that the HCP or	consortium that I am representing satisfies all of the
requirements herein and will abide by all of the relevant requirements, inc	luding all applicable FCC rules, with respect to universal
service benefits provided under 47 U.S.C. Sec. 254. I understand that an	
made available for the benefit of the applicant may be subject to rescission	n.
48 x I hereby certify that the billed entity will maintain complete billing records	for the service for five years.
49 x I certify that I am authorized to submit this request on behalf of the above	-named Billed Entity and HCP, and that I have examined this
form and attachments and that to the best of my knowledge, information,	and belief, all statements of fact contained herein are true.
50 Signature Colon u An	51 Date 7/18/2017
52 Printed name of authorized person Geoff Boggs	53 Title or position of authorized person CEO
54 Employer of authorized person USF Healthcare Consulting, Inc	55 Employer's FCC RN 0018694075

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To: 16 W 4th St; Grant City, MO 64456

This is an Evergreen service / RHC # 836350

HCP:

17908

Bluebird Network

acct # NWMEDC

Spin:

143027882

FRN

1691145

20M PTP VLAN Ethernet ID ALBB-VLAN-14309-01-STTK

Rural Rate:

\$3,000.00

Urban Rate:

99.98 x 2 = 199.96

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Approval by OMB 3060—0804

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	City Albany		11 State MO 12 Zip 64402
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17	Type of Service & Circuit Bandwidth (Documentation re	quired) PTP 20M Ether	rnet
	Total Billed Miles O		wable Distance (From Form 465)
20	Percentage of HCP's service used for the provision of h		
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			**
İ	,		
		······································	
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29	Tariff, Contract or other document reference number	793353	
30	Date Contract Signed or Date HCP Selected Carrier	11/14/2014	
31	Contract Expiration Date (mm/dd/yyyy or NA if MTM)	12/28/2017	
32	Service Installation Date	12/29/2014	
	Actual Rural Rate per Month (Enclose Documentation)	1800.00	
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	Are you a mobile rural health care provider?	1	e instructions and attach a list of all sites to be served.

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Block 7: Bid Documentation				
45 Did you receive any bids in response to the Form 465 Request for S	Services poste	ed on the RHCD website?	Yes	x No
If you checked yes, copies of the bids MUST be submitted to RHCD	•			<u></u>
Block 8: Certification				
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52 Printed name of authorized person Geoff Boggs		53 Title or position of au	thorized person CE	0
54 Employer of authorized person USF Healthcare Consulting, I	Inc	55 Employer's FCC RN	0018694075	

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HCP:

17908

Bluebird Network acct # NWMEDC

Spin:

143027882

20M PTP VLAN Ethernet ID ALBB-VLAN-14309-01-ALBB

Rural Rate: \$1800.00

Urban Rate:

2 x 99.98 = 199.96

466

Health Care Providers Universal Service Funding Request and Certification Form

Approval by OMB 3060--0804

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Estimated time per response: 3 hours

Block 1: HCP Information		
1 HCP Name Northwest Medical Center		2 HCP Number 18338
3 Form 465 Application # 43144764 4	Consortium Name (If any)	
Block 2: Bill Payer Information		
5 Billed Entity Name Northwest Medical Cent	er-Stanberry Rural Healt	6 Billed Entity FCC RN 0002504975
7 Contact Name James Crouch		
8 Address Line 1 202 E Main St.		
9 Address Line 2		
10 City Stanberry		11 State MO 12 Zip 64489
	Fax #	15 Email james.crouch@northwestmedicalce
Block 3: Funding Year Information		
16 Funding Year - Check only one box Year 2014 (7/1/2014-6/30/2015)	Year 2015 (7/1/2015-6/30)/2016) x Year 2016 (7/1/2016-6/30/2017)
Block 4: Service Information	1 Cal 2010 (111/2010-0/00	real 2010 (7/1/2010-0/30/2017)
17 Type of Service & Circuit Bandwidth (Documenta	tion required) PTP 20M Ether	rnet
18 Total Billed Miles O		vable Distance (From Form 465)
20 Percentage of HCP's service used for the provision	on of health care. 100	(If less than 100%, please explain.)
If the HCP indicated it is a part-time eligible entity		d of allocating prorated support.
Connection Information	Carrier A	Camp B (camp Camp Camp D)
21 Service Provider Name	Bluebird Network	
22 Service Provider Identification Number (SPIN)	143027882	
23 Service Provider Contact Person Name	Michael Morey	
24 Service Provider Contact Person's Phone #	816-361-8821	
25 Service Provider Contact Person Email	michael.morey@bluebirda	
26 Circuit Start Location	202 E Main St. Stanberry	
27 Circuit Termination Location	705 N College, Albany MO 64402	
28 Billing Account Number	NWMEDC	
29 Tariff, Contract or other document reference num	nber 793401	
30 Date Contract Signed or Date HCP Selected Car	rier 11/14/2014	
31 Contract Expiration Date (mm/dd/yyyy or NA if M	TM) 2/2/2020	
32 Service Installation Date	2/3/2015	
33 Actual Rural Rate per Month (Enclose Document		
34 If you are a consortium member OR have multipli interconnect and which carrier(s) provides each of		
mission and mission outlier(a) provides each	- Olicult Dis	agram included: Yes x No
35 Are you a mobile rural health care provider?	Yes x No If yes, see	e instructions and attach a list of all sites to be served.

IF YOU ARE REQUESTING SUPPORT FOR MILEAGE-BASED CHARGES, COMP	ETE BLOCK 5 ONLY AND SKIP BLOCK 6. (PLEASE SEE
INSTRUCTIONS). IF YOU ARE REQUESTING SUPPORT BASED ON URBAN/RU	RAL RATE COMPARISON, SKIP BLOCK 5 AND
COMPLETE ONLY BLOCK 6. YOUR APPLICATION CANNOT BE PROCESSED IF	BOTH BLOCKS ARE COMPLETED.
Block 5: Mileage-based Charge Discount Request	
Complete this block if you are seeking support for mileage (distance-based) charges	only. Do not enter any other charges in this block. You may need
to ask your service provider representative to provide this information	
36 Billed Circuit Miles	
37 Monthly Mileage Charges (Exclude Channel Termination chgs, etc.)	
38 Cost per Mile per Month	
If Line 33 equals Line 37, please ensure that ONLY mileage-related charge	s are included in Line 37. (See instructions.)
Block 6: Comprehensive Rate Comparison Request	
Complete Block 6 if you have not completed Block 5 and are requesting support for a	Il elements of your telecommunications service necessary for
the provision of health care. The information in this block will establish the difference	between the urban and rural rates for your requested service.
Please contact RHCD at (800 453-1546 if you need assistance. 39 One-time Urban Rate Charge (in selected large city)	
40 One-time Rural Rate Charge (in city where HCP is located)	
41 Monthly Urban Rate (in selected large city). From RHCD website: or Other rate documentation attached:	
If your circuit includes charges for mileage over the Maximum Allowable Dist., (I	ing 10) places complete Lines 42 to 44. Otherwise, skip to Black 7.
	ine 19), please complete Lines 42 to 44. Otherwise, skip to block 7.
42 Billed Circuit Miles	
43 Monthly Mileage Based Charges	
44 Cost per Mile per Month	
Block 7: Bid Documentation	
45 Did you receive any bids in response to the Form 465 Request for Services pos	ted on the RHCD website? Yes x No
If you checked yes, copies of the bids MUST be submitted to RHCD.	
Block 8: Certification	
46 x I certify that the above named entity has considered all bids received and	
requested service or services. The "most cost-effective service" is define	
lowest cost after consideration of the features, quality of transmission, re necessary for the service to adequately transmit the health care services	
47 x Pursuant to 47 C.F.R. Secs. 54.601 and 54.603, I certify that the HCP of	
requirements herein and will abide by all of the relevant requirements, in	
service benefits provided under 47 U.S.C. Sec. 254. I understand that ar made available for the benefit of the applicant may be subject to rescissi	
48 x I hereby certify that the billed entity will maintain complete billing records	for the service for five years.
49 x I certify that I am authorized to submit this request on behalf of the abov form and attachments and that to the best of my knowledge, information	, and belief, all statements of fact contained herein are true.
50 Signature W a A	51 Date 7/13/2017
52 Printed name of authorized person Geoff Boggs	53 Title or position of authorized person CEO
54 Employer of authorized person USF Healthcare Consulting, Inc	55 Employer's FCC RN 0018694075

- You must submit one Form 466 for each service (i.e., circuit) for which you request reduced rates. For example:
 - If you are requesting reduced rates for two T1 lines, you must submit two Forms 466.
 - If you are requesting reduced rates for two ISDN lines & one Frame Relay line, you must submit three Forms 466.
- If the service described on this form is subject to the 28-day competitive bidding requirement, do not select a carrier or complete the Form 466 before or during the 28-day posting period.
- You must provide evidence of the urban rate if you have completed Block 6 and have not used the urban rates from the website.
- This form, attachments, and supporting documents should be combined in one envelope and sent to the RHCD.
- If the service described on this form changes (e.g., rate change) during the funding year, you must notify RHCD immediately and submit a revised Form 466.
- If you have any questions, contact RHCD at (800) 453-1546.

Persons willfully making false statements on this form can be punished by fine or forfeiture under the Communications Act, 47 U.S.C. Secs. 502, 503(b), or fine or imprisonment under Title 18 of the United States Code, 18 U.S.C. Sec. 1001.

FCC NOTICE FOR INDIVIDUALS REQUIRED BY THE PRIVACY ACT AND THE PAPERWORK REDUCTION ACT

Part 3 of the Commission's Rules authorize the FCC to request the information on this form. The data reported will be used to ensure that health care providers have selected the most cost-effective method of providing the requested services as set forth in 47 C.F.R. Section 54.603(b)(4). The information will be used by the Universal Service Administrative Company and/or the staff of the Federal Communications Commission, to evaluate this form, to provide information for enforcement and rulemaking proceedings and to maintain a current inventory of applicants, health care providers, billed entities, and service providers. No authorization can be granted unless all information requested is provided. Failure to provide all requested information will delay the processing of the application or result in the application being returned without action. Information requested by this form will be available for public inspection. Your response is required to obtain the requested authorization.

The public reporting for this collection of information is estimated to average 3 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the required data, and completing and reviewing the collection of information. If you have any comments on this burden estimate, or how we can improve the collection and reduce the burden it causes you, please write to the Federal Communications Commission, AMD-PERM, Paperwork Reduction Act Project (3060-0804), Washington, DC 20554. We will also accept your comments regarding the Paperwork Reduction Act aspects of this collection via the Internet if you send them to pra@fcc.gov. PLEASE DO NOT SEND YOUR RESPONSE TO THIS ADDRESS.

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THE FOREGOING NOTICE IS REQUIRED BY THE PRIVACY ACT OF 1974, PUBLIC LAW 93-579, DECEMBER 31, 1974, 5 U.S.C. 552a(e)(3) AND THE PAPEWORK REDUCTION ACT OF 1995, PUBLIC LAW 104-13, OCTOBER 1, 1995, 44 U.S.C. SECTION 3507.

Northwest Medical Center- Stanberry Rural Health Clinic

202 Main St

Stanberry, MO

64489

Start—705 N College; Albany, MO 64402 END-- 202 Main St; Stanberry, MO 64489

This is an Evergreen service / RHC # 793401

HCP:

18338

FRN:

Bluebird Network acct # NWMEDC

Spin:

143027882

20M PTP VLAN Ethernet

ID ALBB-VLAN-14309-01-MAVB

Rural Rate:

\$2200.00

Urban Rate: $99.98 \times 2 = 199.96$

Health Care Providers Universal Service Funding Request and Certification Form

Approval by OMB 3060—0804

The deadline to submit this form is the June 30th end of the funding year.

Estimated time per response: 3 hours

	L. LICD Information				-		
	i: HCP Information Name Northwest Medical Center-Ne	w Ha	moton Clinic	2	HCP Number 3	30931	
	m 465 Application # 43144769 4		ortium Name (If any)	1-	TOT HUITOUT	JUBU 1	
	2: Bill Payer Information	COHO	ordani Hamo (n any)				
	d Entity Name Northwest Medical Center	er-Nev	w Hampton Clinic	6	Billed Entity FC	C RN 000250	04975
	tact Name James Crouch			1	<u>-</u>	 	· · · · · · · · · · · · · · · · · · ·
	ress Line 1 304 E Lincoln St						
9 Add	ress Line 2					****	
10 City	New Hampton			11	State MO	12 Zip 6447	71
13 Con	stact Phone # 660-726-1261 14	Fax#		15	Email james.	crouch@nort	hwestmedicalc
	3: Funding Year Information						
	ding Year - Check only one box		Year 2015 (7/1/2015-6/30	0/201	6) ×	Year 2016 (7/1	/2016-6/30/2017)
	4: Service Information						
	e of Service & Circuit Bandwidth (Documenta	tion red			D' 1		
	al Billed Miles ()		19 Maximum Allov		······································		
	centage of HCP's service used for the provision				- '	0%, please expl	ain.)
If the	e HCP indicated it is a part-time eligible entity	(on Fo	orm 465), describe metho	od of a	allocating prorate	ea support.	
<u> </u>							
	S AMAZONIA SANDAMA						2. 1012.0
04.0	Connection information	and god	Carrier A	# Car		Paniero	Carrier D. Carrier
-	vice Provider Name		Bluebird Network				
	vice Provider Identification Number (SPIN)		143027882				
	vice Provider Contact Person Name		Michael Morey				ļ
<u> </u>	vice Provider Contact Person's Phone #		816-361-8821				
	vice Provider Contact Person Email		michael.morey@bluebird				
	cuit Start Location		304 E Lincoln St, New Hampton, MO 64471				
	cuit Termination Location		705 N College, Albany MO 64402 +				
	ng Account Number		NWMEDC				
	iff, Contract or other document reference num		793402			,	
30 Dat	te Contract Signed or Date HCP Selected Car	rier	11/14/2014				
31 Cor	ntract Expiration Date (mm/dd/yyyy or NA if M	TM)	1/12/2020				
32 Ser	vice Installation Date		1/13/2015				
	ual Rural Rate per Month (Enclose Document		2400.00				
	ou are a consortium member OR have multipl		•		-	- Commenced	
inte	erconnect and which carrier(s) provides each	circuit :	segment. Circuit D	iagra	m included:	Yes	x No
35 Are	you a mobile rural health care provider?		Yes x No If yes, se	ee inst	tructions and att	ach a list of all s	ites to be served.

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COMPLETE ONLY BLOCK 6. YOUR APPLICATION CANNOT BE PROCESSED IF	BOTH BLOCKS ARE COMPLETED.
Block 5: Mileage-based Charge Discount Request	
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46 x I certify that the above named entity has considered all bids received and	selected the most cost-effective method of providing the
requested service or services. The "most cost-effective service" is defined	
lowest cost after consideration of the features, quality of transmission, rel	
necessary for the service to adequately transmit the health care services	
47 x Pursuant to 47 C.F.R. Secs. 54.601 and 54.603, I certify that the HCP or	consortium that I am representing satisfies all of the
requirements herein and will abide by all of the relevant requirements, inc	
service benefits provided under 47 U.S.C. Sec. 254. I understand that any	
made available for the benefit of the applicant may be subject to rescission	•
48 x I hereby certify that the billed entity will maintain complete billing records	
49 x I certify that I am authorized to submit this request on behalf of the above form and attachments and that to the best of my knowledge, information,	and belief, all statements of fact contained herein are true.
50 Signature (A) a M	51 Date 7/18/2017
52 Printed name of authorized person Geoff Boggs	53 Title or position of authorized person CEO
54 Employer of authorized person USF Healthcare Consulting, Inc	55 Employer's FCC RN 0018694075

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Northwest Medical Center- New Hampton Clinic 304 E Lincoln St

New Hampton, MO

64471

Start-705 N College; Albany, MO 64402

END-- 304 E. Lincoln St; New Hampton, MO 64489

This is an Evergreen service / RHC # 793402

HCP:

30931

FRN:

Bluebird Network

acct # NWMEDC

Spin:

143027882

5M PTP VLAN Ethernet

ID ALBB-VLAN-14309-01-BTHN

Rural Rate: **\$2400.00**

Urban Rate:

99.98 x 2 = 199.96

Missouri Network Alliance LLC 2005 W. Broadway Building A, Suite 110 Columbia, MO 65203

Billing Inquiries: Disputeresolution@bluebirdnetwork.com



Northwest Medical Center, Assn Attn: Attn: James Crouch 705 N College St Albany, MO 64402-

Albany, MO 64402

BAN NWMEDC
INVOICE NUM 17863
INVOICE DAT 7/1/2016
DUE DATE NET 30
SERVICE DAT July 2016

ACCOUNT SUMMARY

PREVIOUS BALANCE	\$16,766.75
PAYMENTS	\$16,766.75
BALANCE PAST DUE	\$0.00
CURRENT CHARGES	\$16,766.75
TOTAL AMOUNT DUE	\$16,766.75
REMOVE AND RETURN THE LOWER SEC	CTION WITH YOUR PAYMENT. THANK YOU.
SEND PAYMENTS TO: Missouri Network Alliance LLC 2005 W. Broadway Building A, Suite 110	AMOUNT PAID
Columbia, MO 65203	

remit to:

INVOICE

Missouri Network Alliance LLC D

800 NW Chipman Road Suite 5750 Lees Summit, MO 64063-

InvoiceNo: 17863

Due: Net 30

Northwest Medical Center, Assn

Billing Account Code: NWMEDC

Attn: James Crouch

Invoice Date 07/01/2016

705 N College St Albany, MO 64402

Invoice For Month Of: July

Circuit	ALBB-VI	LAN-14309-01-ALBE	3			
Serv.	Month	Description		UnitRate	Units:	Amount
	led	ICD	Individual Occupation	04 000 00		
	Jul Jul	ICB MoUSF	Individual Case Basis	\$1,800.00	1	\$1,800.00
	Jui	MOOSE	Missouri USF Surcharge	\$1.80	1	\$1.80
A Location:		llege St: Albany, MO 64		136 Bus :Albany.	MO 64402	
Purchase Orde	er Number N	IW Center Albany Clinic- 2	20Mb Origin Date: 12/29/2014		Circuit Total:	\$1,801.80
Circuit	ALBB-VI	_AN-14309-01-BTHI	N			
Serv.	Month	Description		UnitRate	Units:	Amount
	Jul	ICB	Individual Case Basis	\$2,400.00	1	\$2,400.00
	Jul	MoUSF	Missouri USF Surcharge	\$2.40	1	\$2.40
A Location:	705 N Co	llege St.: Albany, MO 64	Z Location: 304 E Linco	In St: New Hampte	on. MO 64471	
Purchase Orde	er Number N	W Medical New Hampton	- 5Mb Origin Date: 1/13/2015		Circuit Total:	\$2,402.40
Circuit	AL BB-\/I	AN-14309-01-MAV	В			
	Month	Description	5	UnitRate	Units:	Amount
		2 000. pt. 017		O'mir (ato	Orms.	Amount
	Jul	ICB	Individual Case Basis	\$2,200.00	1	\$2,200.00
	Jul	MoUSF	Missouri USF Surcharge	\$2.20	1	\$2.20
A Location			ŭ	•	•	\$2.20
A Location:	705 N Co	MoUSF illege St.; Albany, MO 644 W Medical Stanberry- 201	402 Z Location: 202 Main St	: Stanberry, MO 6	4489	\$2.20
Purchase Orde	705 N Co er Number <u>N</u>	illege St:Albany, MO 64- W Medical Stanberry- 20	402 Z Location: 202 Main St Mb Origin Date: 2/3/2015	: Stanberry, MO 6	•	
Purchase Orde	705 N Co er Number N	illege St.: Albany. MO 64- W Medical Stanberry-20I AN-14309-01-STTF	402 Z Location: 202 Main St Mb Origin Date: 2/3/2015	: Stanberry, MO 6	4489 Circuit Total:	\$2,202.20
Purchase Orde	705 N Co er Number <u>N</u>	illege St:Albany, MO 64- W Medical Stanberry- 20	402 Z Location: 202 Main St Mb Origin Date: 2/3/2015	: Stanberry, MO 6	4489	\$2.20 \$2,202.20 Amount
Purchase Orde	705 N Coer Number N ALBB-VI Month	llege St.: Albany, MO 64- W Medical Stanberry-20I LAN-14309-01-STTM Description	7402 Z Location: 202 Main St 7402 Z Location: 202 Main St 7402 Mb Origin Date: 2/3/2015	Stanberry MO 6	4489 Circuit Total: Units:	\$2,202.20 Amount
Purchase Orde	705 N Co er Number N	illege St.: Albany. MO 64- W Medical Stanberry-20I AN-14309-01-STTF	Z Location: 202 Main St Mb Origin Date: 2/3/2015	UnitRate	4489 Circuit Total: Units:	\$2,202.20 Amount \$3,000.00
Purchase Orde Circuit Serv.	705 N Coer Number N ALBB-VI Month Jul Jul	W Medical Stanberry- 201 AN-14309-01-STTH Description ICB MoUSF	Z Location: 202 Main St Mb Origin Date: 2/3/2015 Individual Case Basis Missouri USF Surcharge	UnitRate \$3,000.00	4489 Circuit Total: Units: 1	\$2,202.20 Amount \$3,000.00
Purchase Order Circuit Serv. A Location:	705 N Coer Number Illege St.: Albany. MQ 64- W Medical Stanberry- 20I AN-14309-01-STTH Description ICB MoUSF	A102 Z Location: 202 Main St Mb Origin Date: 2/3/2015 Individual Case Basis Missouri USF Surcharge Z Location: 16th W 4th S	UnitRate \$3,000.00 \$3.00	4489 Circuit Total: Units: 1 1	\$2,202.20 Amount \$3,000.00 \$3.00	
Purchase Order Circuit Serv. A Location:	705 N Coer Number N ALBB-VI Month Jul Jul 705 N Co	W Medical Stanberry- 201 AN-14309-01-STTH Description ICB MoUSF	Z Location: 202 Main St Mb Origin Date: 2/3/2015 Individual Case Basis Missouri USF Surcharge Z Location: 16th W 4th S	UnitRate \$3,000.00 \$3.00	4489 Circuit Total: Units: 1	\$2,202.20 Amount
Purchase Order Circuit Serv. A Location: Purchase Order	705 N Coer Number N ALBB-VI Month Jul Jul 705 N Coer Number N	Illege St.: Albany. MQ 64- W Medical Stanberry- 20I AN-14309-01-STTH Description ICB MoUSF	A02 Z Location: 202 Main St Mb Origin Date: 2/3/2015 (Individual Case Basis Missouri USF Surcharge 402 Z Location: 16th W 4th S Mb Origin Date: 5/18/2015	UnitRate \$3,000.00 \$3.00	4489 Circuit Total: Units: 1 1	\$2,202.20 Amount \$3,000.00 \$3.00
Purchase Order Circuit Serv. A Location: Purchase Order Circuit	705 N Coer Number N ALBB-VI Month Jul Jul 705 N Coer Number N	Illege St.: Albany, MO 644 W Medical Stanberry- 201 AN-14309-01-STTM Description ICB MoUSF Illege St.: Albany, MO 644 W Medical Grant City- 20	A02 Z Location: 202 Main St Mb Origin Date: 2/3/2015 (Individual Case Basis Missouri USF Surcharge 402 Z Location: 16th W 4th S Mb Origin Date: 5/18/2015	UnitRate \$3,000.00 \$3.00	4489 Circuit Total: Units: 1 1	\$2,202.20 Amount \$3,000.00 \$3.00
Purchase Order Circuit Serv. A Location: Purchase Order Circuit	705 N Coer Number N ALBB-VI Month Jul 705 N Coer Number N ALBB-VI Month	Illege St : Albany, MO 644 W Medical Stanberry- 201 AN-14309-01-STTM Description ICB MoUSF Illege St : Albany, MO 644 W Medical Grant City- 20 AN-14309-02-ALBE Description	A02 Z Location: 202 Main St Mb Origin Date: 2/3/2015 Individual Case Basis Missouri USF Surcharge A02 Z Location: 16th W 4th S Mb Origin Date: 5/18/2015	UnitRate \$3,000.00 \$3.00	4489 Circuit Total: Units: 1 1 64456 Circuit Total:	\$2,202.20 Amount \$3,000.00 \$3.00 \$3,003.00
Purchase Order Circuit Serv. A Location: Purchase Order Circuit	705 N Coer Number N ALBB-VI Month Jul 705 N Coer Number N ALBB-VI Month Jul	Illege St : Albany, MO 644 W Medical Stanberry- 201 LAN-14309-01-STTM Description ICB MoUSF Illege St : Albany, MO 644 W Medical Grant City- 20 LAN-14309-02-ALBE Description ICB	A02 Z Location: 202 Main St Mb Origin Date: 2/3/2015 (Individual Case Basis Missouri USF Surcharge 402 Z Location: 16th W 4th S Mb Origin Date: 5/18/2015 Individual Case Basis	UnitRate \$3,000.00 \$3.00 St : Grant City. MO UnitRate \$1,800.00	4489 Circuit Total: Units: 1 1 64456 Circuit Total: Units:	\$2,202.20 Amount \$3,000.00 \$3.00 \$3,003.00
Purchase Order Circuit Serv. A Location: Purchase Order Circuit	705 N Coer Number N ALBB-VI Month Jul 705 N Coer Number N ALBB-VI Month	Illege St : Albany, MO 644 W Medical Stanberry- 201 AN-14309-01-STTM Description ICB MoUSF Illege St : Albany, MO 644 W Medical Grant City- 20 AN-14309-02-ALBE Description	A02 Z Location: 202 Main St Mb Origin Date: 2/3/2015 Individual Case Basis Missouri USF Surcharge A02 Z Location: 16th W 4th S Mb Origin Date: 5/18/2015	UnitRate \$3,000.00 \$3.00 \$t: Grant City, MO	4489 Circuit Total: Units: 1 1 64456 Circuit Total: Units:	\$2,202.20 Amount \$3,000.00 \$3,003.00 Amount \$1,800.00
Purchase Order Circuit Serv. A Location: Purchase Order Circuit Serv. A Location:	705 N Coer Number N ALBB-VI Month Jul Jul 705 N Coer Number N ALBB-VI Month Jul Jul Jul Jul Jul Jul Jul Jul Jul Jul	illege St : Albany, MO 644 W Medical Stanberry- 201 AN-14309-01-STTH Description ICB MoUSF Illege St : Albany, MO 644 W Medical Grant City- 20 AN-14309-02-ALBE Description ICB MoUSF ICB ICB ICB ICB ICB ICB ICB ICB ICB ICB	A02 Z Location: 202 Main St Mb Origin Date: 2/3/2015 (Individual Case Basis Missouri USF Surcharge A02 Z Location: 16th W 4th S Mb Origin Date: 5/18/2015 Individual Case Basis Missouri USF Surcharge	### Company Co	4489 Circuit Total: Units: 1 1 64456 Circuit Total: Units: 1 1	\$2,202.20 Amount \$3,000.00 \$3.00 \$3,003.00 Amount \$1,800.00
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remit to:

INVOICE

Missouri Network Alliance LLC D

800 NW Chipman Road Suite 5750 Lees Summit, MO 64063-

	Jul	MoUSF	Missouri USF Surcharge	\$3.25	1	\$3.25
A Location:	705 N Co	ilege St : Albany, MO	2 Location: <u>1102 Gra</u>	and Av MMR: Kansas (MR: Kansas City, MO 64106	
Purchase Orde	r Number <u>N</u>	W Medicall Center- 10	Origin Date: 1/1/2015		Circuit Total:	\$3,253.25
Circuit	KCBB-V	LAN-14309-03-AL	BB			
Serv.	Month	Description		UnitRate	Units:	Amount
	Jul	ICB	Individual Case Basis	\$2,300.00	1	\$2,300.00
	Jul	MoUSF	Missouri USF Surcharge		1	\$2.30
A Location:	1102 Gra	nd Av Ste 1010: Kansa	s City. MO 64106 Z Location: 705 N Col	llege St:Albany, MO	64402	
Purchase Orde	r Number N	W Medical Center Mair	1 Hospt- 50M Origin Date: 12/29/2014		Circuit Total:	\$2,302.30

INVOICE TOTAL:

\$16,766.75



KCFiber / liNKCity

201 E 16th Ave. NKC, MO 64116

(816) 412-7990

BUDGETARY QUOTE FOR SERVICES

Client: Bluebird Network

Number of Sites: 2

Contact: Accounts Payable

Address: 2005 W Broadway, Bldg. A, Ste 110

Columbia, MO. 65203

Prepared by: Nicolai Laquaglia Account Executive: Nicolai Laquaglia

Contact: 816-412-7812 | Nicolai@KCFiber.com

Date: May 15th, 2017

DESCRIPTION OF SERVICES: Point to Point – (P2P)

KCFiber / liNKCity to provide a 100 Mbps Symmetrical circuit via Fiber Ethernet - to be delivered to

connect the following address sites:

A Location: 1925 Burlington St, North Kansas City, MO 64116

Z Location: 1102 Grand Blvd, Kansas City MO. 64106

Full 24/7 – 365 Business Class Support

Service Type	Anticipated Service Installation Date	Non-Recurring Charge	Monthly Recurring Payment	Term					
A: 100Mbps Ethernet Fiber Access	ТВА	\$99.99	\$99.98	МТМ					
Z: 100Mbps Ethernet Fiber Access			\$99.98	МТМ					
	Total	\$99.99	\$199.96						
Account Executive: Middle Date: 5/16/17									